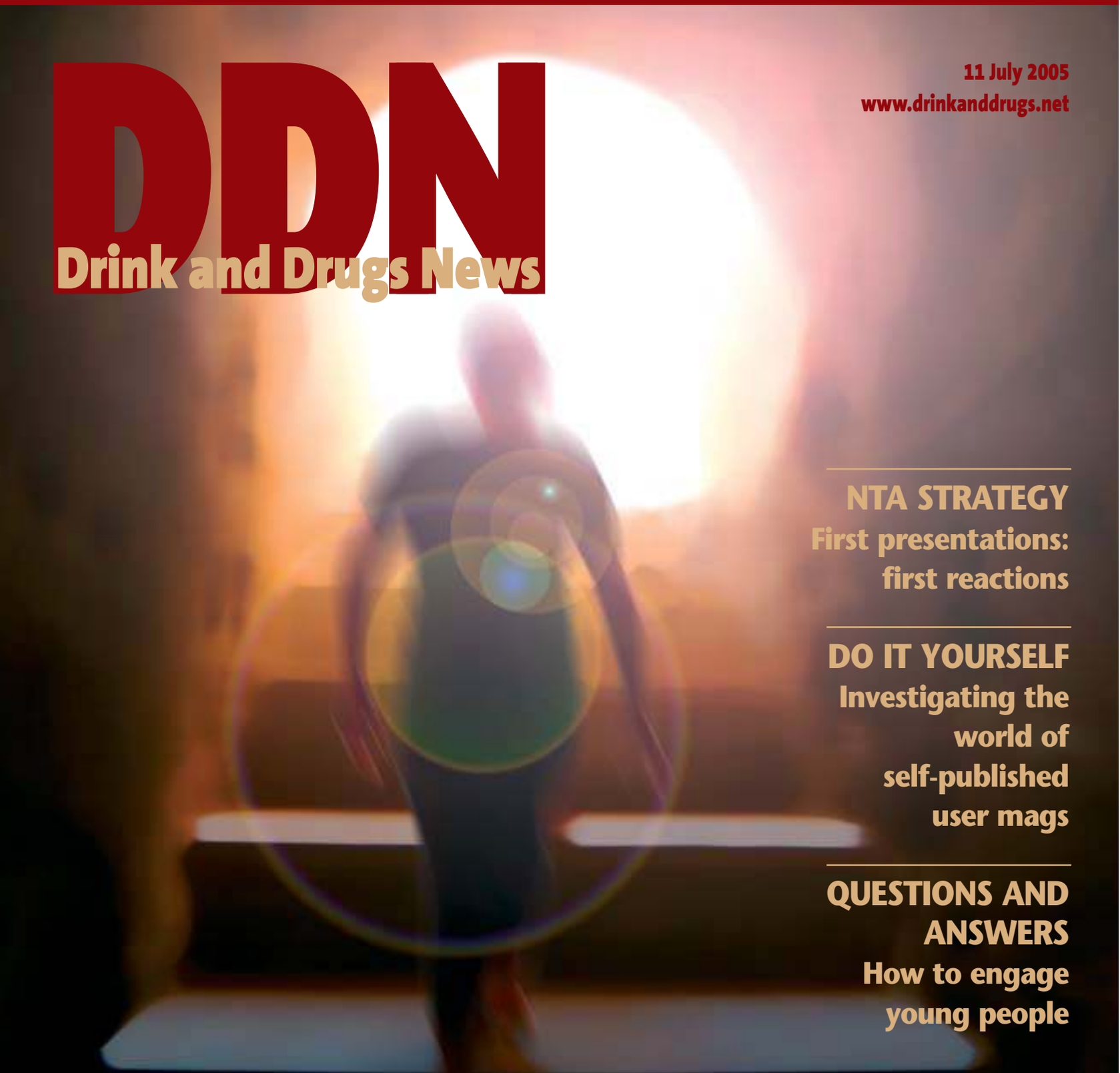
From FDAP in association with WIRED

DDN
Drink and Drugs News

11 July 2005
www.drinkanddrugs.net



NTA STRATEGY
First presentations: first reactions

DO IT YOURSELF
Investigating the world of self-published user mags

QUESTIONS AND ANSWERS
How to engage young people

THE LONG WALK TO FREEDOM
Alcoholics Anonymous – 70 years and 12 steps

Your fortnightly magazine | jobs | news | views | research

UKAS accredited drug testing

TrichoTech
Leaders in drug testing

Hair Analysis:

- Unique long window of detection profiles drug use typically over 3 months
- Ideal for matching self-reporting with actual drug history before, during and after treatment
- Used by over 120 clinics and hospitals, most local authorities, police and health professionals
- Differentiates between regular and intermittent use
- Provides a fuller picture of drug history – difficult to evade
- Simple and quick to collect with high donor tolerance

Oral Fluids Analysis:

- Provides an 'under the influence' snapshot of drug use
- Good for assessing drugs in the body the day the sample is collected
- Many advisors switching from urine to saliva tests for practicality and dignity
- Simple and quick to collect with high donor tolerance

Urine Analysis:

- Profiles drug use from 1 – 4 days prior to sample collection
- Cheap on-site screening-only results available
- Less dignified and more time consuming to collect than hair or saliva

UKAS TESTING

TrichoTech is the only UK laboratory to have UKAS accreditation for drug testing hair, saliva and urine. (certificate 2212)

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Drink and Drugs News

11 July 2005

Editor's letter

'User involvement is meaningless if it's just at a low level' – one of Anna Millington's comments to the NTA conference to launch the new three-year strategy (page 6). The NTA has taken care to involve service users in feedback to the strategy, and there is enthusiasm for its dedication to putting service users' needs first. But Anna's comment does sum up the need for continued consultation.

Leaving the conference there was appreciation among service-using delegates of the open presentation of plans; but the big PS to the event has to be the need for continued dialogue to take the exercise beyond paper and into joint planning over the next three years. We've already had feedback from one delegate (letters, page 9).

The preferred way for some user groups to get messages across is through their own publication (page 12). Editors of three different styles of mag share their experiences of setting up and keeping going. Sorting out the distribution isn't always straightforward, but the value of communicating directly has proved extremely worthwhile. It need not be a slick or complicated operation, as long as it's reliably regular – so let's hope for continued funding to sustain their efforts. The benefits extend beyond the readership, to those who get involved in production. As *Off The Wall* found, there are plenty of creative people who come in the door, and it's a great way of rekindling forgotten skills.

Our cover story this issue takes a detailed look behind the theory and practice of 12-step support – help and inspiration to so many over the last 70 years.

The next issue of *DDN* (out on 25 July) will be our last before we take a break for two issues in August. Please don't stop the contributions and feedback coming – we love to hear from you.

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In this issue

Media watch

Profit margins for heroin traffickers into Britain are so high that they outstrip luxury goods companies such as Louis Vuitton and Gucci, according to half of a study that Downing Street has withheld from publication under freedom of information legislation. The report delivers a scathing verdict on efforts to disrupt the drugs supply chain and was leaked to the *Guardian*, which speculated on the government's refusal to publish less than favourable news on the eve of the Live 8 concert.
The Guardian, 5 July

A beer made with a caffeine additive is to be launched in the UK – amid fears that it might fuel binge drinking. A spokesman for BE – Beer with Extra – which also contains guarana, and ginseng said 'it will be marketed at people aged 18 to 34 who like drinking in bars and nightclubs'. Andrew McNeill, the director of the Institute of Alcohol Studies, said he was concerned that the caffeine content might encourage people to drink alcohol for longer periods.
The Scotsman, 4 July

A new study into alcohol use in Blackpool has revealed one in six people in the resort has been hospitalised through alcohol since 2000 and there are up to 90 preventable deaths a year through drink abuse. Problems are also gripping the emergency services – figures show more than a third of arrests made in Blackpool involve drunks. Director of Public Health for Blackpool Fylde and Wyre, Dr Andy Howe, said: 'alcohol harm has become a priority due to the high levels of drink-related crime, injury and alcohol-related disease experienced in Blackpool'.
The Blackpool Gazette, 7 July

New research hints at why it's so hard to quit smoking. In a study on mice, Pennsylvania researchers found that nicotine affects the brain through the same mechanism as heroin and other opiate drugs. Part of nicotine's hold on smokers is believed to be due to its effect on brain levels of dopamine, which is associated with feelings of wellbeing. But there is evidence from several studies that nicotine also causes a rise in levels of opioids – naturally occurring chemicals that are similar to opiate drugs.
Reuters, 16 June

Kids as young as 15 are signing up for self-help meetings in a bid to kick their cocaine habits. Cocaine Anonymous Scotland has revealed how a growing number of youngsters are becoming addicted to the drug and they claim that cocaine abuse has reached 'epidemic' proportions. Experts blame the falling cost of the drug and the fact it is now far more readily available, for the rise in abuse.
Daily Record, 7 July

Pete Docherty claims his shambolic performance at Live 8 had nothing to do with drugs. He says he was flustered because Geldof's daughter Peaches had pinched his behind before he want on stage. He said: 'I wasn't lost for words and I wasn't out of it on drugs. Just before I went on stage Peaches squeezed my bum hard and whispered something rather suggestive to me. It left me in such shock I didn't know where I was.'
Daily Mirror, 6 July

Scottish boost to alcohol and drug funding announced

Scottish alcohol and drug action teams have been told they will receive additional funding of £9 million this year. The £5 million earmarked for alcohol services will take the total for rehabilitation services and public education on the dangers of drinking to £10 million.

The extra £4 million for drugs will enable DATs to increase the numbers going into drug treatment by at least 2,000, contributing to the Scottish Executive's target of increasing the number of people entering treatment from 12,600 in 2003/2004 to 15,600 in 2006/2007.

Justice Minister, Cathy Jamieson, said the extra funding was 'to help those who had developed problems 'to choose to turn their backs on drugs and crime and to fulfil their potential'. The money would give support where it was needed and help to reduce local waiting times. Increasing co-ordination between services would help to 'loosen the dealers' grip on communities', she added.

Deputy health Minister, Lewis MacDonald, said the investment addressed Scotland's culture of binge drinking that 'brought misery to thousands of people each year'.

The announcement was welcomed by the Scottish Drugs Forum, which stressed that it was crucial for the extra cash to go to frontline projects or services that would have the greatest impact on reducing harm.

Until detailed plans were presented, the SDF would have reservations about the Executive's decision to ringfence £2 million for the £6 million additional funding promised last year, for criminal justice interventions.

Health and criminal justice services needed to be much better co-ordinated to prevent drug-using offenders from lapsing back into drugs and crime, said SDF director David Liddell: 'We cannot have a situation where an addict successfully completes a Drug Treatment and Testing Order… only to find that when his or her DTTO ends, he or she is forced to rejoin the back of the queue for mainstream drug services in the community.'

Scrutiny toolkit will aid alcohol strategies

Alcohol Concern has launched a 'scrutiny toolkit' to help local authorities take a more strategic approach to reducing alcohol-related harm in their communities.

The kit includes suggested questions for proposed witnesses and has been welcomed by Gareth Wall of the Centre for Public Scrutiny as 'one of the most comprehensive resources aimed at local government scrutinisers we have seen'.

Geethika Jayatilaka, Alcohol Concern's director of policy and public affairs, said the kit had been designed to help local authorities address neglected ways of dealing with alcohol related harm. While they had been 'vocal about the impact of licensing changes on their residents', they often lacked a strategic approach to action.

Alcohol fuels 50 per cent of violent crime, is associated with 60 per cent of child protection cases, and causes one in four of the public to cite drunk and rowdy behaviour as a problem in their neighbourhood, says the charity.

Euromed bursary registration opens for next year

The Euromed Training and Accreditation Bursary for drug treatment workers has now closed for the academic year 1995-1996. Designed to give financial support to three individuals for placements on accredited training programmes, there have been over 120 applications, many of whom found out about the scheme through DDN. The three winners will be announced here in October. Anyone interested in applying for the next academic year can register at Euromed's website – www.euromed.ltd.uk
There is also an opportunity for additional course providers to be included in next year's bursary – details are also available on Euromed's website.

Helen Massey-Roche (left), chief executive or Alcohol and Drugs Abstinence Service ADAS, receives her award as a 'social entrepreneur'. The Maxie Richards award from the Centre for Social Justice recognised her work with the only non-residential abstinence service in the North West, which includes a structured day care programme for the homeless. Ms Massey-Roche attributed the award to the commitment of her 15-strong team, 'who care about making a difference'.

Conference – Sentenced to Treatment – meeting the needs of drug using offenders

Drug crime link

The drugs crime link has driven everything forward, NTA chief executive Paul Hayes told the Sentenced to Treatment conference in London.

'It's the reason everyone here is in a job,' he told delegates.

Acknowledging the improvements needed in the prison system, Mr Hayes said the NTA's new three-year strategy would engage at all stages, through arrest, remand, community and custodial sentencing and release.

'We need to join up systems to get an integrated system of care in prisons,' he said. Joint work between the Home Office and PCTs would increase the likelihood of prisoners accessing the treatment they needed.

An effective treatment needed capacity and the system was on track to double by 2008. Waiting times were being reduced from ten weeks to two, and the NTA had a goal to hold people in treatment for three months or more. Progression was high on the agenda: 'it's not enough to dose them up with methadone and forget about them,' said Mr Hayes. 'They need to get their kids back, get into education and health systems, move towards being employed.'

People were not signing up for treatment for life, and needed moving through the system quicker. Treatment needed to be tailored and relevant to their needs, but Mr Hayes was optimistic that they would respond to the prospect of coming off treatment earlier: 'Drug users are duckers and divers, entrepreneurs, people who can take control of their life,' he commented.

Opportunities for contact through criminal justice system

'Long term success is about entirety of services,' said Peter Wheelhouse, director of the Drug Intervention Programme. Aftercare delivery had to move up the agenda, involving employment, accommodation and training.

The number of people entering DIP was up and acquisitive recorded crime down, he told delegates. There was an 11 per cent reduction in drug related crime.

Getting in contact with drug users through the criminal justice system was far more effective than persuading them to engage, according to Mr Wheelhouse.

The Drugs Act, allowing drug testing on arrest, could offer 'a major step up' in tripling the number of drugs tests carried out, he said.

A shortage of good, qualified people in the sector posed problems: 'We've got to grow a skilled and sustainable workforce and get away from chasing the same people round the system.' DANOS, training and apprentice schemes would help to raise standards, and he called for 'better information-sharing all round'.

Delegates at the conference, who represented treatment services and all areas of criminal justice, all had a common goal, said Mr Wheelhouse. 'It's about sustainability and long-term mainstreaming – giving the client a seamless journey.'

Centralised approach to engagement

Criminal justice intervention teams are a new approach to getting throughcare for offenders, with a particular focus on engagement, explained Paul Turnbull, deputy director of the International Centre for Policy Research.

Fieldwork with teams on 20 sites found 'a variable understanding of what case management is,' he said. Agencies had different cultures and priorities, and tensions around information-sharing could be a thorn in the side.

CJITs needed to define operational roles and care pathways clearly: 'A centralised approach seems to work best,' he said. Some CJIT staff were working in silos and it was important that cultural change happened at grass roots level.

There needed to be an increase in the pool of staff, together with resources for induction and training and standardisation of job descriptions and pay scales.

Although information-sharing was patchy, there was gradual progress towards delivery, said Mr Turnbull.

'A strong foundation needs to include coherent leadership, strong partnerships, clear aims and objectives,' he commented.

Criminal justice vs health debate still polarised

'There is still a criminal justice versus health debate, but it's still polarised – probation versus the treatment sector, courts versus the treatment sector,' Peter Martin, chief executive of Addaction, told conference.

It had taken time for the government to be persuaded of the value of treatment, said Mr Martin: 'Treatment is not popular with the public, it is not a vote winner.'

The massive expansion through criminal justice had demanded different ways of working, he said, with alternatives to custody now more accepted.

A 'criminal justice pathway model' gave better responsiveness and joined-up working,' he commented. But gaps in throughcare and aftercare undermined good work in prisons.

As many as 85 per cent of people targeted under the Prolific and other Priority Offenders (PPO) strategy had basic drug treatment needs. Bringing criminal justice to the top of the agenda had achieved progress, but there was a need for quality in treatment delivery, said Mr Martin.

People came into prison with baggage, and a 'lava bed of emotional turmoil' beneath their behaviour, but had nowhere to put it all: 'If the drug worker doesn't address this baggage, the barrier to change won't be lifted,' he told delegates.

Mr Martin added his support to the call for better staff training and more effective housing solutions.

Treatment and Testing Orders a 'watershed'

Drug Treatment and Testing Orders had been a watershed in working with drug misusing offenders, according to Fiona Bauermeister, national drugs and alcohol interventions manager for the National Probation Service.

But there had been practical difficulties with the 'one size fits all' approach, so the more flexible Drug Rehabilitation Requirement (DRR) would offer treatment more closely tailored to individual needs. DRRs were subject to mandatory court reviews after 12 months and would require offenders to be tested twice a week for the first 16 weeks (or once a week in residential rehab).

The transition from DTTO to DRR was a challenge, said Ms Bauermeister, but the system was based on building on good practice. Robust internal and external processes were essential, she said, 'or we will struggle to meet targets'.

Communication would aid processes, and probation needed to play an active part in DATs' business and planning. Criminal justice was now a key route into treatment, and 'engaging and monitoring offenders in treatment must be our primary goal,' she told conference.

Criminal justice 'a wedge in the door'

Criminal Justice is trying to stick a wedge in the revolving door, said Jez Huyton or Humberside Police. 'When people are arrested, it's a good time to intervene with them.'

The drug testing process only tells us they have a problem – it doesn't cure it, he commented. 'Clinics around Hull are full to capacity. The challenge is to identify needs, provide good treatment and then wraparound services like housing,' he said.

One of the biggest challenges was to make sure when prisoners came out of the gates, there was someone there to take them: 'There's no point in doing good work in prison, if they're straight back in contact with old friends. They need diverting into a new life.'

The challenge was to make sure services were in place, said DC Huyton. 'We need to keep them in treatment and not abandon them when funding runs out.'

The conference chair, DrugScope head of policy Dr Marcus Roberts, summed up that coerced treatment could be very effective, but it was now about retention and making sure there were services around treatment, especially housing. 'There are plenty of challenges ahead,' he commented.

The Sentenced to Treatment conference was held in London on 29 June by the Centre for Crime and Justice Studies. Visit www.kcl.ac.uk/ccjs

NTA maps the road ahead

The National Treatment Agency has launched a new treatment effectiveness strategy for the next three years, which will affect everyone working in substance misuse. At a London conference, the NTA outlined the plan, invited feedback from representatives from diverse areas of the field – and urged everyone working with services to put their support behind making it work. DDN reports.

'Unless we can hold people for three months or longer, the effort will be wasted.'

NTA chief executive

Waiting times are down, there's a dramatic increase in capacity, and the workforce has expanded, said NTA chief executive, Paul Hayes.

So why was the NTA launching a treatment strategy now? 'We need to start focusing on retention,' he explained. 'Unless we can hold people for three months or longer, the effort will be wasted.'

He promised the NTA would be proactive in working with service users and with support services – housing, social services, education, health, employment – to make sure clients get access to the services they need.

The other priority would be to address underperforming services: he acknowledged that the worst services have been measured as seven times poorer than the best, 'a ratio that is not defensible'.

The NTA would spend time working directly with service providers, he said, and would improve the quality of commissioning, which is 'nowhere near good enough. We need to make sure they have adequate understanding, are supported, and are of the right calibre.'

Service providers needed to take a good look at their structure and their workforce. 'Are you structured right?' he asked. 'Do you have the right workforce? Is your management strong enough?' Practitioners needed to be proactive – prepared to learn from services that were doing things better than they were, willing to integrate with other services, and keen to engage service users by making sure they were getting what they needed.

There were major challenges over the next three years, said Hayes. Success, in his eyes, meant 'a stable, responsive, effective system that's service user and community led'. In basic terms, this meant 'all people who want to, will be able to get treatment that's good enough to make a difference to their lives.'

Failure would mean 'going back to 2001 – people waiting 10 weeks, not making a difference, and moving people out of treatment before they're ready'.

The strategy was timed to take advantage of 40 cent more investment next year – 'then the gravy train will come to an end in 2008,' he said. 'By then we will need to have created a system that will survive.'

'...more active effort to engage clients and keep them in treatment.'

NTA director of quality

Service users are at the heart of this strategy, said Annette Dale-Perera, the NTA's director of quality: 'We want more active effort to engage clients and keep them in treatment.'

Studies have shown that the average time spent in drug treatment is six years, during which time significant progress can be made, she said. Service users may be episodic – their use of services may be done in chunks. 'But the more chunks they have, the better they do each time they go in.'

Half of clients were being lost within the first three weeks. 'We have to stop this major revolving door… retention is the new mantra,' she said.

Practical initiatives were underway. Care planning and review tools were being developed by Dr Emily Finch, head of the NTA's clinical team, to be implemented in March next year. A new 'orange book' was being produced for doctors, on prescribing.

'We want to create better exit doors,' said Dale-Perera. The plan was to expand residential rehab – 'we will try to address funding provision for inpatient services and residential rehab,' and develop drug-related aftercare to suit the individual. 'We want to expand the Narcotics Anonymous/ Alcoholics Anonymous model, as not everyone responds to 12 steps.'

A different approach was needed – a re-interpretation, she said. 'We need to start at the delivery stage, not the end.' This involved working with partners – housing, employment, education, commissioning. Commissioning partners must have a better understanding of local needs, and plan for them better. And there must be 'an investment approach' to staff, as a competent workforce was a critical success factor.

The strategy was about a 'step change approach', but depended on the right mindset, she said. These are 'bold plans… and need the help of everybody out there'.

'Positive change requires deliberate attention and resources.'

Director of the Institute of Behavioural Research

'Retaining people in services for longer is made more likely by better assessment, higher methadone doses, better monitoring, comprehensive wraparound services, and meeting clients' needs, according to Prof Dwayne Simpson, co-author or DATOS (Drug Abuse treatment Outcome Studies).

Research highlighted the gulf between best and worst services: the best programme reviewed kept 65 per cent of people in treatment over three months; the worst kept only 21 per cent.

'Changes don't happen automatically or easily,' he said. 'Positive change requires deliberate attention and resources.'

'Success will be measured by deeds and not words.'

DrugScope chief executive

'Success will be measured by deeds and not words,' said DrugScope's chief executive, Martin Barnes. 'There's been much progress – and much more to do.' Referral targets for 2008 were ambitious but achievable, said Barnes. But he was concerned at the preoccupation with targets: 'It is right to question how quality will go alongside quantity? The management regime of Tesco's is not appropriate for drug treatment.'

Expanding the workforce had already exacerbated problems of recruitment and retention, he said, with accompanying issues of inequality of pay and conditions and cannibalisation from other areas of the field. So the NTA's support for workforce development was welcome – 'but we need stronger commitment to training'.

The NTA was right to demand quality from service providers, 'but they need to be resourced and

rewarded'. Commitment to service users was the right strategy, he said – 'but it mustn't be seen as tokenist'.

Benefits to clients were what were important, 'however we get there', and this meant keeping dogfights (eg on harm reduction) out of treatment. The government should not be afraid to look at safe injecting rooms and experience from abroad – it was about what worked, he said.

Keeping focus on drug treatment to 2008 and beyond was essential. 'The chancellor has indicated that the next round of funding may be tough,' said Barnes. We must not allow a return to the days when drug treatment was left at the margins.'

'...NTA displaces many of its target tasks onto PCTs.'

Chief executive, Newark and Sherwood PCT

David Sharp represented Newark and Sherwood PCT – 'the NHS out of hospital'.

'The NTA displaces many of its target tasks onto PCTs,' he said. A key task was getting GPs and pharmacies on board and working with families. Community pharmacies were one of the best ways of engaging and working towards de-stigmatisation of services.

Sharp said PCTs were not 'part of the industry' but had a statutory role to be leader in communities and to work with families, GPs, pharmacies and drug users.

'What's the point of increasing capacity, when we're not using the capacity we've got?'

EATA chief executive

'Is the strategy of putting the client at the centre something new?... Why weren't they there before?' asked Ian Robinson, chief executive of EATA.

While supporting the aims of the strategy, he disputed some areas, such as discussing retention rates as a panacea. 'Rates are an indicator of success, not success itself, at the end of the day,' he said.

Robinson disputed that commissioning had improved: 'eighty per cent of services [surveyed] didn't have contracts in place'.

Bureaucracy in teams was being dealt with by more bureaucracy, he said: 'Organisations cannot do the job they should be being paid to do'. He also urged the NTA and DATs to commit to prompt payment: 'Residential organisations can't survive if they're not paid on time.'

He supported the commitment to a competent workforce, but added that commissioners should also be DANOS competent.

He also welcomed 'huge investment', but said there was more scope within the existing workforce: 'What's the point of increasing capacity, when we're not using the capacity we've got?' Prejudice against 12-step treatment, for example, was limiting options.

Making the further suggestion that the NTA should make more of its regional teams to monitor DATs who are not using residential services, he was optimistic that 'if this strategy is embraced, we can move forwards'.

'If people don't value the user's voice, it's likely they're not valuing them.'

NTA national users' advisory group representative

Anna Millington of the NTA national users' advisory group stressed the importance of care planning – an NTA key objective.

'Treatment without care planning is demeaning,' she said. 'Medication is not enough.' She had had her first care plan last week, after four years in treatment.

User involvement was meaningless, if it was just at low level, said Millington. 'If people don't value the user's voice, it's likely they're not valuing them.' Investment in user involvement had to be a priority, she said. 'A tick box exercise is not good enough any longer. We need to see evidence trails, not just data output.'

Services should be better tailored to support families, and to meet the needs of women. Places were often not child friendly, and services were not always sympathetic to minority groups.

'Hard to reach can mean hard to cater for,' she commented. Millington had support for the strategy in theory, but was concerned it could be let down at delivery level.

'We need clearer evidence of what's working and why,' she said. The NTA needed to be more assertive and directive where more support was needed:

'The drug user has a right to be treated like any other medical client – unless this is recognised, it doesn't matter what strategy is brought out.'

'We mustn't imagine we will be better at housing than housing workers. We will need to discuss sensible limits.'

Chief executive, Lifeline

The substance misuse field is seeing the staggering impact of growth, said Ian Wardle, chief executive of Lifeline. 'We're building a large, ambitious, career-orientated industry.'

In seeing the numbers go up, it was important to make progress, realising that we couldn't solve all problems at once. He was concerned that drugs workers should not encroach on the patch of experts in the wider field: 'We mustn't imagine we will be better at housing than housing workers. We will need to discuss sensible limits to our field.'

The NTA was immediately adjacent to government and had to translate the fashions of the day, he commented. In the immediate term there were priorities to address: 'We haven't identified the needs and aspirations of different groups of users.'

'We're in danger of deluding ourselves... There's lots written down centrally that doesn't necessarily happen.'

Head of Addiction Research Unit

The way in which treatment is delivered matters enormously in our field, commented Professor John Strang, head of King's College Addiction Research Unit. 'It's at least as important as what's being delivered itself.'

The most effective treatment went beyond methadone and incorporated counselling and active rehabilitation support. A 'levels of care' study had shown a massive difference in usage patterns and employment for those receiving all three levels of treatment.

Research had uncovered 'worryingly low' doses of methadone prescribing for maintenance.

'We're in danger of deluding ourselves,' he said. 'There's lots written down centrally that doesn't necessarily happen.'

The NTA's new strategy key points

The strategy aims to improve the service user's journey through treatment, by:

- Improving engagement. Access to treatment is promised within three weeks (faster for certain groups), underpinned by harm reduction services and support.
- Improving retention. The aim will be to keep service users in treatment for at least 12 weeks – the minimum needed for bring about long-term benefit.
- Improving delivery. Every service user will have a written care plan, agreed with them. Annual inspection, review and audit by the NTA and Healthcare Commission will weed out poor practice.
- Improving rehab and routes out of treatment. The NTA will seek to expand inpatient detox and residential rehab opportunities. They will work on improving links with housing, education and employment to improve access for service users.
- Improving commissioning. The NTA has announced it will launch a programme to improve commissioning competency, to bring all treatment providers up to the standard of the best.

'To get individuals off drugs, we need to introduce them to viable alternatives. We're clearly not doing that...'

Chief officer, In-Volve

'The reality of drug services is not "very variable" – it's very poor,' said chief officer of In-Volve, Viv Ahmun, also representing the Federation of Black and Asian Drugs Workers.

'To get individuals (that want to) off drugs, we need to introduce them to viable alternatives. We're clearly not doing that at the moment.'

While fully engaging service users was 'absolutely correct', Ahmun was concerned at the 'urgency' of the NTA strategy.

Outreach provision was weak, prison work was demoralising, carat workers needed to be supported and resourced, and it was vital to engage with young people. Enthusiasm needed to be kindled and was central to effective training: 'The best workers are passionate about what they do. It's infectious,' said Ahmun.

Diversity was not about identifying 'marginalised' groups, but about good business practice. 'You have to determine who's in an area and set about meeting those needs.'

The NTA needed to make its messages heard: 'You have to sell this, you have to make it work,' he told the NTA.

'Together we're tackling drugs and changing lives.'

Minister for Public Health

'Banging the drum across the country' to link drug issues with the public health agenda was the promise of Caroline Flint MP, newly transferred from the Home Office to the Department of Health.

The outlook was positive, with lowest numbers of people dying from drug abuse since 1997. The 55 per cent increase in allocations to DATs to 2008 represented 'funding on an unprecedented scale', and the Prime Minister had signed up to the benefits of funding drug programmes, she said. She was forging a close partnership with Paul Goggins at the Home Office.

Health in prison raised huge challenges, that would be addressed by the Department of Health's £40m for the prison service.

But she was concerned at the 'huge disparities in services across the country' and stressed the importance of engaging communities.

The NTA strategy could be effective in focusing minds on making sure service users were not just passive recipients, but could work towards independent living. She stressed the need for partnerships to give better access to housing, education and employment, and said there needed to be improvement at all levels.

'Together we're tackling drugs and changing lives,' said Flint.

'Quantity needs to be underpinned with quality... It's about having an individual approach to individuals.'

Consultant psychiatrist

Having a strategy was very important, but people needed to be treated comprehensively, said Dr Eilish Gilvarry.

'Quantity needs to be underpinned with quality,' she said. 'It's about having an individual approach to individuals.'

Commissioners and providers all needed to be fit for purpose and staff should be welcoming and competent. The treatment journey was about engagement across all tiers, not just a one-way journey from engagement, to treatment, to exit.

A holistic view should be a core standard for all of us, she said. We must involve users, but also support families and carers, she said.

Most crucial was the dialogue between users and providers, and 'we won't get a dialogue unless we're transparent'.

'I am ashamed you can't walk into any practice and expect courtesy and decent treatment.'

Director of primary care

'It's a very good strategy, a very good beginning,' said Dr Clare Gerada, but there were 'still some problems with what we've heard today'.

One of the main challenges was 'to get all of you to understand what we do in primary care... we are doing treatment and are not outside it. We are the industry – we have it within our four walls... housing, chiropody, you name it'.

Primary care was often seen as a 'bolt-on' she said, but there were around 50,000 patients managed from GP services.

Pharmacies were the 'hidden jewel in the crown', and would be able to prescribe from April.

While celebrating the three-fold increase in GP involvement with drug users, it was important to recognise the challenge of improving services for patients and making them more uniform.

'I am ashamed you can't walk into any practice and expect courtesy and decent treatment,' she said. 'There is excellent treatment in some, but bad care in others.'

'We must invest to make a difference on the ground.'

Chief executive, FDAP

'While we have largely met the NAT's targets for "more treatment", we still have some way to go in relation to the goal of "better treatment",' said Simon Shepherd, chief executive of the Federation of Drug and Alcohol Professionals.

There was room for improvement in unlocking the potential of workers – in which organisations like the NTA and FDAP played a key role.

'We need to find ways of recognising skills and knowledge and ensuring competence,' said Shepherd. DANOS provided a framework to identify shortfalls in skills and knowledge, but it was not about making DANOS qualifications compulsory – more about making sure people in the field were competent, and protecting clients from incompetent practitioners.

Counselling was an important part of the treatment field, and highly skilled and competent work. 'We need to make sure counsellors are properly trained,' he said.

To train and develop staff cost money, but was essential, said Shepherd: 'We have to resist buckling under and not investing properly in staff... we must invest to make a difference on the ground.'

Resources need to be focused on pioneering neighbourhood initiatives that involved education, prevention and rehab.

Director of Neighbourhood Renewal Strategy, ODPM

The Neighbourhood Renewal Strategy had seen progress in closing gaps of health and inequality in deprived neighbourhoods, according to Alan Davis from the Office of the Deputy Prime Minister.

He welcomed the NTA strategy and said resources needed to be focused on pioneering neighbourhood initiatives that involved education, prevention and rehab.

The ODP was funding a number of programmes to reintegrate drug users into society. **DDN**

Have your say: email our letters page, claire@cjwellings.com

Re: 'Harm Reduction is not a ticket to recovery'

Am I missing something here or does Roy Fisher simply not understand what harm reduction is (*DDN* letters, 27 June). He thinks *DDN* supports a harm minimisation model as a form of 'recovery' which I take from his letter he doesn't agree with. Although *DDN* has recently featured an article on a rehash of an old 12-step faith based programme, 'recovery' is not a term I have ever heard used in the harm reduction field, nor have I ever heard anybody claim it is a form of recovery. Harm reduction is about reducing drug related harm (the name is a bit of a giveaway). He then goes on to state the 'bleeding obvious' that users find it hard to control their drug use and says 'I cannot subscribe to the theory that people given time and a methadone prescription will eventually sort themselves and the real danger here is that many service users die in the contemplation mode'.

Let me make it simple for you Roy, methadone does sort some people out. Try getting out and meeting some people who are alive because of methadone or maybe even reading some research. Second, it is not passing through a stage of Prochaska and DiClemente's theoretical model that kills people – it is overdoses and blood borne viruses. Harm reduction's primary purpose is to reduce deaths caused by these and other factors. Harm reduction in Britain started in the 1980s because treatment services and the old concept based therapeutic communities were totally abstinence based (including my own service, Lifeline). They had woeful success rates, even among the few who chose to go along to them and were as much use as a chocolate fireguard when faced with the threat of HIV amongst injectors. A harm reduction philosophy has never precluded helping people stopping or supporting people who want to be abstinent, but it recognises that many fail and are at increased risk of overdose and sharing if they go back to using. I agree with one thing that Roy Fisher says: 'whilst at work we must work within a framework of giving the service users choices'. Harm reduction, in the form of needle exchange, safer use information, methadone and other prescribing options should be part of the choice on offer to everyone, even in those services that spend there time challenging addiction 'in a respectful manner'.

Michael Linnell, Director of Communications, Lifeline

'A harm reduction philosophy has never precluded helping people stopping or supporting people who want to be abstinent, but it recognises that many fail and are at increased risk of overdose and sharing if they go back to using... Harm reduction, in the form of needle exchange, safer use information, methadone and other prescribing options should be part of the choice on offer to everyone, even in those services that spend their time challenging addiction "in a respectful manner".'

NTA: Don't underestimate the value of continuity

I have just returned from the NTA conference to launch the new treatment effectiveness strategy, which was edifying and raised my expectation for 'service user participation'.

BUT – at the final Q&A I managed to get in a question ('today has been very encouraging, but isn't it pointless when, every three years, you throw everything that's been done up in the air and insist the contracts for alcohol and drugs services go out to tender?') in a plea for stability for service users on their 'journey'. The answers were so dismissive that it made me think that Saul Bellow was right when he said 'a great deal of intelligence can be invested in ignorance when the need for illusion is deep'.

Politicians, and funding authorities for that matter, require evidence that they're getting 'value for money' but are clueless as to what 'value' is. It is only the service user who understands the true value of the service he receives, and it can't be measured.

When an addict, be it alcohol or drugs, and goes into treatment, he soon realises that he's going to be forced to make some radical changes to his way of life. This requires even more difficult changes in his way of thinking. These changes will mean making many difficult choices, and to do that he will need the help of someone he can trust, somebody who is non-judgemental and free of dogma, to work out all of his options with him, and give him a better chance of making the best one.

It's a long and difficult journey, made easier by the help of many and various caring people. But being bereft of any self-worth, let alone self-confidence, it may take a little time to establish a rapport with the practitioners at his service; but when he does, a bond is created that is to become the foundation on which he will base his road-map for the journey to 'being normal'.

With his support structure in place, he is up and running, ready to make some of those difficult choices, With his mutually drawn-up care-plan and needs assessment in place, peer support around the corner at his first 'day course', there is light at the end of the tunnel. With services, some of which he had never heard (like-auricular acupuncture), there to help him, he can be forgiven for being optimistic about his future sobriety. Unrecognised by all, including himself but more ironically by those insistent on measuring outcomes, something very subtle has happened to our friend. Since 'detox' he has not been fighting his problems alone. He's had counselling and advice from people who are caring and supportive, and peer support that is empathetic from colleagues on the same journey as he is. This compassion, for someone on their own, is probably the closest they have been to being loved for a long, long time. This can have a great deal of influence on the effectiveness of 'recovery'. Measure it if you can!

Meanwhile, back at the PCT, 'the system' is (thanks to our politicians) ready to kick away the support under our alcoholic/addict, and rubbish all the PCT's efforts to meet its meaningless targets. It is time for the contracts for alcohol and drugs services go out to tender. 'Patient needs' driven NHS..?

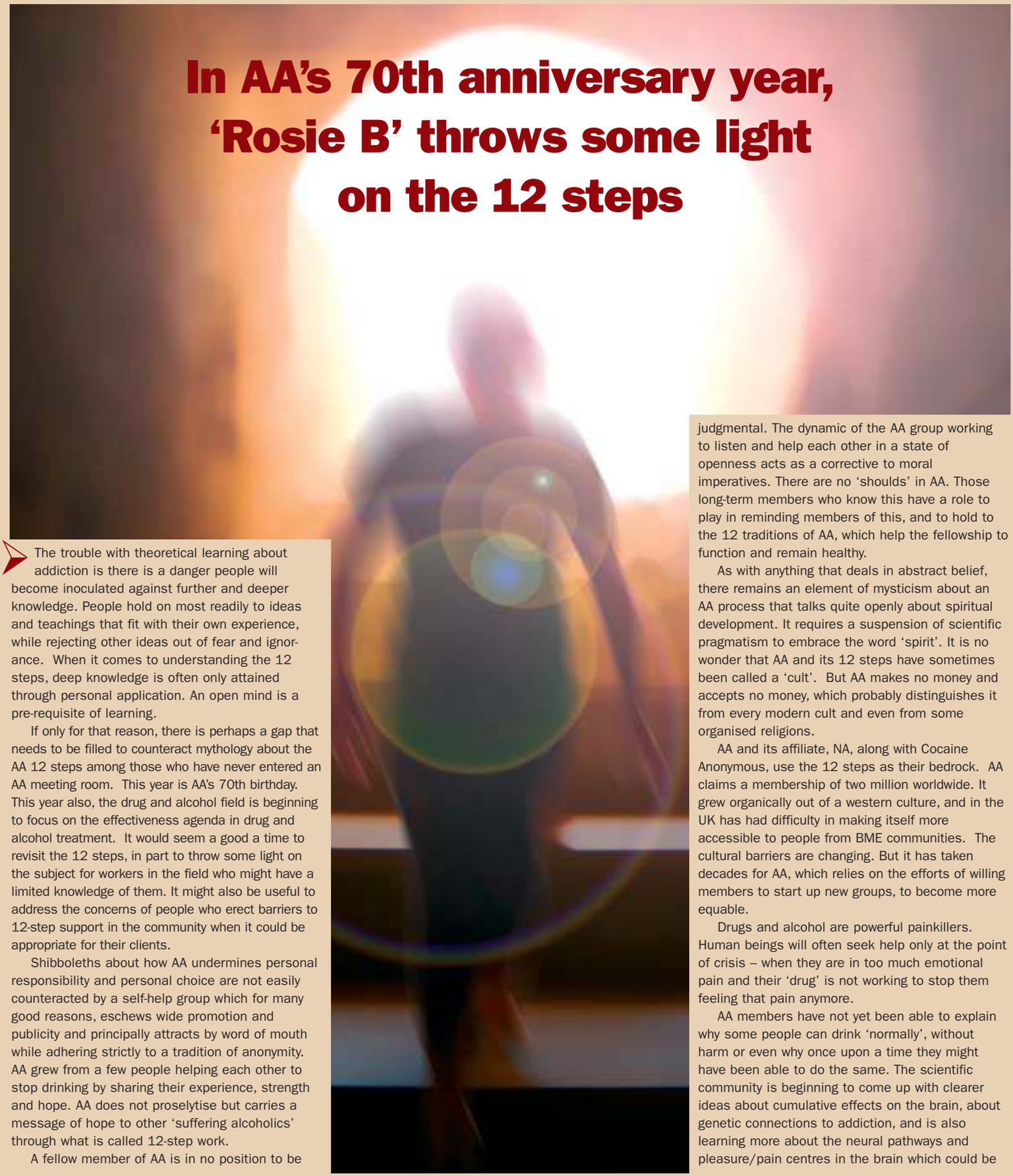
Now with a new service provider, and not knowing if same professionals, whose trust and support were the foundation of his fight back, will still be there for him, our friend may be forgiven for coming to the conclusion that he had been right all along – he wasn't worth it. Hopefully he'll have become strong enough to start again.

Surely it's not beyond the wit of the PCTs to forego this so called 'modernisation' when it is damaging to the patient. Providers, GPs, DAATS, commissioners – all have their corners to defend, what chance, or choice, does the service user have? I can't help thinking that, with the help of service users' experience, a service, provided by a consortium of existing providers working together, using the 'Models of Care' protocols already in place, would not only produce 'best practice' but also 'best value'.

Martin Saunders, 'As If...' (Alcohol Services Independent Forum), London

Email your letter to claire@cjwellings.com. Letters may be edited for reasons of length and clarity.

In AA's 70th anniversary year, 'Rosie B' throws some light on the 12 steps



The trouble with theoretical learning about addiction is there is a danger people will become inoculated against further and deeper knowledge. People hold on most readily to ideas and teachings that fit with their own experience, while rejecting other ideas out of fear and ignorance. When it comes to understanding the 12 steps, deep knowledge is often only attained through personal application. An open mind is a pre-requisite of learning.

If only for that reason, there is perhaps a gap that needs to be filled to counteract mythology about the AA 12 steps among those who have never entered an AA meeting room. This year is AA's 70th birthday. This year also, the drug and alcohol field is beginning to focus on the effectiveness agenda in drug and alcohol treatment. It would seem a good a time to revisit the 12 steps, in part to throw some light on the subject for workers in the field who might have a limited knowledge of them. It might also be useful to address the concerns of people who erect barriers to 12-step support in the community when it could be appropriate for their clients.

Shibboleths about how AA undermines personal responsibility and personal choice are not easily counteracted by a self-help group which for many good reasons, eschews wide promotion and publicity and principally attracts by word of mouth while adhering strictly to a tradition of anonymity. AA grew from a few people helping each other to stop drinking by sharing their experience, strength and hope. AA does not proselytise but carries a message of hope to other 'suffering alcoholics' through what is called 12-step work.

A fellow member of AA is in no position to be judgmental. The dynamic of the AA group working to listen and help each other in a state of openness acts as a corrective to moral imperatives. There are no 'shoulds' in AA. Those long-term members who know this have a role to play in reminding members of this, and to hold to the 12 traditions of AA, which help the fellowship to function and remain healthy.

As with anything that deals in abstract belief, there remains an element of mysticism about an AA process that talks quite openly about spiritual development. It requires a suspension of scientific pragmatism to embrace the word 'spirit'. It is no wonder that AA and its 12 steps have sometimes been called a 'cult'. But AA makes no money and accepts no money, which probably distinguishes it from every modern cult and even from some organised religions.

AA and its affiliate, NA, along with Cocaine Anonymous, use the 12 steps as their bedrock. AA claims a membership of two million worldwide. It grew organically out of a western culture, and in the UK has had difficulty in making itself more accessible to people from BME communities. The cultural barriers are changing. But it has taken decades for AA, which relies on the efforts of willing members to start up new groups, to become more equable.

Drugs and alcohol are powerful painkillers. Human beings will often seek help only at the point of crisis – when they are in too much emotional pain and their 'drug' is not working to stop them feeling that pain anymore.

AA members have not yet been able to explain why some people can drink 'normally', without harm or even why once upon a time they might have been able to do the same. The scientific community is beginning to come up with clearer ideas about cumulative effects on the brain, about genetic connections to addiction, and is also learning more about the neural pathways and pleasure/pain centres in the brain which could be

affected by a range of factors, most particularly in early stages of the brain's development.

The typical AA member often comes to understand through painful experience that knowing why they drink compulsively is a less important question than how to stop drinking. In contrast, for the scientist, 'why' is the all-important question that precedes the finding of the cure.

The 'loss of control' concept, favoured by psychiatry, by definition implies that control is possible. Controlled drinking may work for some of course, and for others it will not. AA believes that alcohol works on the individual to trigger cravings. AA members never talk about 'cure', they talk about on-going recovery on a daily basis.

Often an individual will arrive at AA meetings with complex underlying problems that they feel they can't talk about in that forum. They may need also to seek other therapy that can help. But whatever an individual may need to change, he or she is ultimately unlikely to be successful in dealing with underlying issues, if self-awareness and feelings are suppressed by drugs or drink.

Perhaps the very first common understanding that AA members come to, is that they are not alone in having a problem. Alcohol dependency can be very isolating.

After acceptance comes the realisation that life is difficult for lots of people, not just for them.

Learning to live well without recourse to alcohol becomes a goal.

AA members offer the 12 steps as one way to live, to make life less difficult for them and for others who have been on the receiving end of their alcohol-induced behaviours. Part of the process involved in the 12-step programme is an honest examination of personal emotions and behaviours that have blocked personal growth.

Often, long before coming to an AA meeting, many will have attempted to control their drinking by calling on self-discipline or 'willpower'. Vast numbers of people of course will neither look for, nor receive, any support and many will die while trying to stop drinking on their own. However, hundreds of thousands of people have been helped to stop their drinking through AA and in the process many of them have changed and helped others. Those who claim a 360-degree change in their lives will usually point to the 12 steps as having made all the difference.

One of the teachings of the 12 steps, takes the idea of managing one's life and stands it on its head. Step one teaches that life is unmanageable. This idea sanctions efforts by individuals to stop trying to control everything – the spinning plates in the air syndrome – characteristic of stress, and in the case of people who drink heavily, often an underlying feature of a displacement, with its concomitant psychological drive to fix things that are external to them or that are not the core issue. Step three suggests individual will is turned over to a higher power, reinforcing the concept that there are some things we just can't control.

Of course spending time trying to fix external things and focusing on fixing others can be frustrating. It is indicative of avoidance. It is not easy for an 'alcoholic' to take a hard look in the mirror. It might interfere with the compulsion to drink.

The first step begins 'we admitted that we were powerless over alcohol'. This challenges a more logical formulation that willpower is the key to change, a belief that is undermined by a persistent failure to stop drinking. A personal acknowledgement of an alcohol or drug problem moves a person from the entrapment of the denial

state on to a sense of release.

Willpower as generally understood, is associated with ego. Surrendering to the reality that far from being able to control their drinking it is the drink that has come to control the individual, contributes to ego-deflation. This surrender leads to acceptance that the individual is not in control of the alcohol. It is not disempowerment, but paradoxically leads to a powerful recognition that through acceptance comes real power to deal with the problem.

Ego-deflation has often been confused by observers of 12-step processes with a diminution of self-esteem. Poor self-worth is a characteristic of many AA members who talk about having deep feelings of inadequacy inside, while presenting a superior defensive stance to the outside world.

For AA members, pride or inflated ego are strong barriers to self-revelation and honest self-assessment. Conversely, having a balanced self-assessment about one's self can help people feel they fit into the world.

The receptiveness of the individual and their ability to connect with emotions can be suppressed by the effects of alcohol. This seems self-evident. But for the novice attempting to deal with their drinking, avoidance can be strong. I know of one member who always talked in terms of thinking rather than feeling. She used to say she could not cry for fear she might drown in her own tears. She sought therapy to work on her feelings of inadequacy and paid £30 an hour for the privilege. She would stop at the off-licence on route to her therapist and drink three miniature vodkas. The alcohol induced a momentary sense of self-worth and blocked those feelings that she was trying to address in therapy. She smiles about it now. Conversely, she once thought she could never go to a party once she had stopped drinking. She would be so dull. She doesn't go to as many now, but she has realised it is possible for her to be fully alive and fully engaged without a drink.

AA members talk about individuals reaching a 'rock-bottom' in their drinking. What constitutes a rock bottom is a personal judgement. Abstinence is promoted as the goal in AA and acceptance by an individual that they may be an 'alcoholic' is not imposed. It might be helpful to suggest that someone has a drinking problem, but no AA member can tell another they are an alcoholic. It wouldn't work. They can only share their own experience. Self-realisation is the key.

The substance misuse field does not find labels helpful. There is associated stigma. There are differences in definition as to what constitutes alcoholism. However, AA members as 'users' have found that a good aid to connection with the group is to introduce themselves by name and when they are ready, to acknowledge they are an alcoholic.

Hearing the stories of other people who have stopped drinking on 'daily basis', whether for a week or several years, encourages the individual 'newcomer' to AA to believe that stopping drinking and change may also be possible for them.

AA has often been criticised for promoting an unscientific 'disease' model of alcohol addiction. More often than not, today's AA members will avoid medical definitions and use the 'disease' description as a way of expressing their feeling of being ill at ease in a world into which they feel they cannot fit without alcohol.

Next issue of DDN, we take a deeper look at steps two and three, and go on to look at what have been called the 'growth' steps, 4 to 12.

Self-published support

Starting a magazine for service users can seem a daunting prospect - but it needn't be. DDN talked to the founders of three very different publications, and discovered that it's all about doing it your own way.

When Colin Stewart-Tribe made contact with the Drugs and Homeless Initiative (DHI) in Bath, he had hit rock bottom. In and out of recovery for 17 years, his thoughts were of basic comfort above anything more aesthetic. Memories of a career as a graphic designer and then a production manager at *Venue* magazine – the local version of *Time Out* – had become lost in the break-up of his life and family.

A chance conversation at DHI rekindled old skills. 'I was talking to Liz, moaning that the notice board was inaccessible and out of date,' he says. 'We started thinking that we could create a log of what goes on at DHI. People needed to know what was happening, what the groups were.'

So the publication started off as a 'what's on, and who's who'. Not only was it nice to know what was going on at the centre; it was useful for newcomers to be able to identify from the printed staff guide who was a member of staff and who was a service user. As Colin points out, it's not ideal to have to wander round interrogating people for help, when you've only just walked in the door.

At last year's AGM, Colin floated the idea for *Off The Wall*. He had just a week or so to put together a mock-up; Liz became editor, Richard did design, and the project was completely client led. 'We wanted it to be professional looking from the start – and we realised there are a lot of creative people that come in these doors,' says Colin. 'We gave them encouragement to have a go – you never know. We were very pleased with the design.'

Things gathered pace rapidly from there. Before they knew it, they had managed to persuade local celebrity Midge Ure (in recovery himself) to come to the launch, and were frantically signing off the first issue just two hours before people arrived for the party.

Colin may be pleasantly surprised by how it all turned out, but from the outset he was realistic about the hard work involved in getting people to commit to the magazine's long-term survival.

'People are always moving on. We could do with a project worker to keep things going long term and give us some continuity,' he realises now.

Resources have always been a priority, and it's been a hand to mouth existence from the first issue – even though 'it's inclusive and client led.... and ticks a lot of boxes'.

They managed to get sponsorship from a local solicitor on the basis of some advertorial in the magazine, 'and have been promised £300 for the next issue from the local DAT'.

For Colin and the team, bringing the magazine to life has given a whole new dimension to user involvement: 'Trusting people is an issue for clients, so we make promises that if you contribute, it will be printed.' He hopes that those in authority will follow suite – particularly where promises of funding are concerned: 'Anyone supporting the magazine needs to follow through.'

So you need enthusiasm to get started, resourcefulness to tackle the funding – and the resilience to make your way past a few false starts, particularly if you're figuring it out in a small team… or a team of one. Small numbers are no obstacle if you've got determination, says David Wright (of *DDN*'s 'Diary of a heroin user' series) – but you've got to be prepared to stick at it.

Fresh from training to be a drug advocate for user involvement, David came back home to Newport in Gwent determined to create a network of local service users.

'I thought right, here I go, I'm going to call a meeting for all the drug users. So I got posters and put them up everywhere. Then on the day, not one person turned up – which I found out wasn't surprising. I'd been asking a lot of shopkeepers, who said "yeah, I'll put it up mate", but I walked round a few days later and they weren't up.

'So I thought "how am I going to get my message across?"' Thinking about the geography of Gwent, the valleys and the hard to reach areas, post seemed the best option. So he got going on his computer with Windows 95 and a newsletter wizard programme, and came across *Daily Dose* on the internet. He put stories from the site into his newly created *Heroin Herald* and sent them to 'places to do with service users' from a directory of south east Wales.

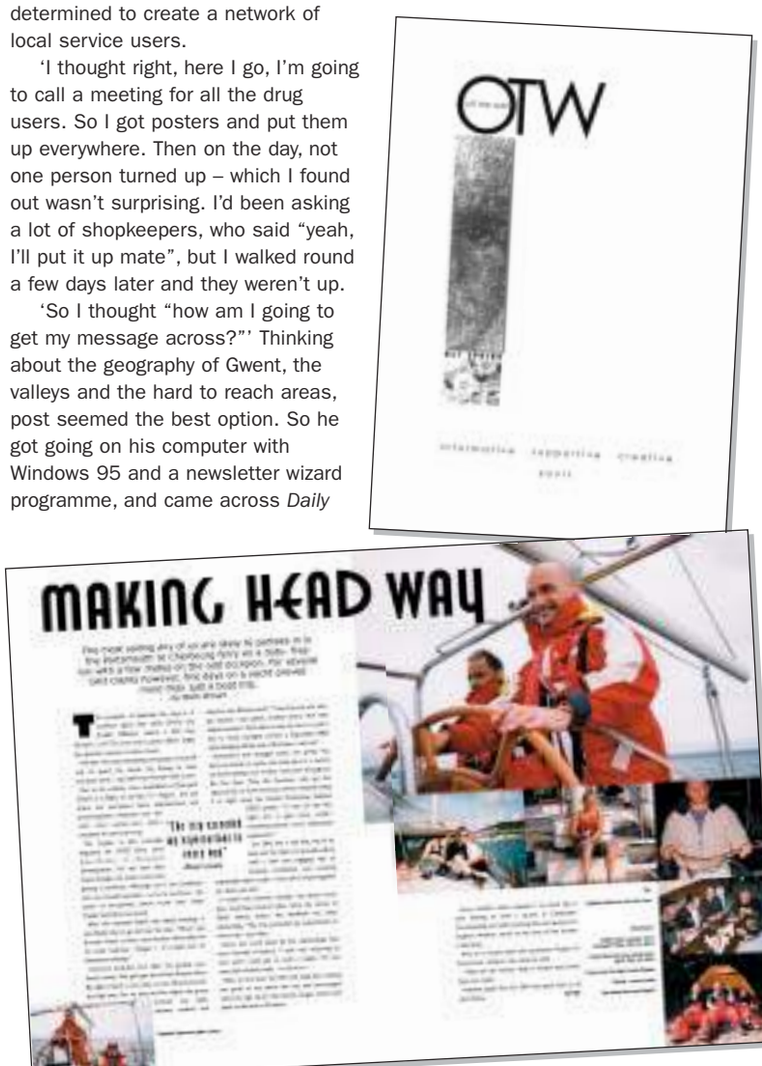
These early editions were all about getting information out, particularly about Hepatitis C – 'because it was such an epidemic. I found stuff that I didn't know, so I knew other users didn't know it – and they needed to.'

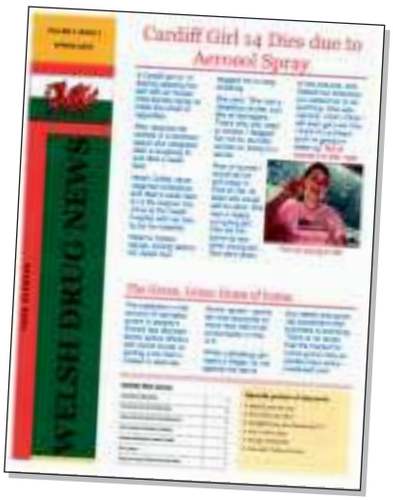
There was no concept of getting a response from readers at this stage, says David. That came later, when he started coming across feedback.

'I used to send it to the psychiatric hospital where people used to go for detox. I thought they would probably rip it up, but I was speaking to one of the nurses and he said "is it you who writes that? It's brilliant, it goes round the wards and they were really impressed with it".'

Soon after, Inroads (an open

'We realised there are a lot of creative people that come in these doors... We gave them encouragement to have a go – you never know. We were very pleased with the design.'





'If it appeals to me as a drug user, it'll appeal to other drug users... It gives service users a platform they trust to write about their own opinions and experiences.'

access drug clinic) got hold of a copy, called David, and asked him if he wanted to come and help set up their service users group, 'Affect'. Settling in at Inroads not only gave him chance to work out the best way of connecting with service users, it also gave him access to a faster computer and MS Publisher programme – new territory of page headings and pictures.

He created *Welsh Drug News* with shorter stories and personal commentary. His criterion for picking stories was 'if it appeals to me as a drug user, it'll appeal to other drug users… I pushed it a bit further, it's a bit naughtier. I take the piss out of the drug squad, Cardiff Prison, things that are in drug users' lives that it's good to have a knock at.' More importantly, he says, it gives service users a platform they trust to write about their own opinions and experiences.

David has now gone nationwide with the *Heroin Herald*, sending it to DATs and hoping it will help with user involvement. He's grateful for the support of the Alliance, for whom he works as a volunteer, and says the rest of it is really about learning as you go along.

'I've learnt from experience to make sure you make a note as soon as people come forward. You take their details – in a diary if you're not so computer literate.' It's about making the most of contacts and making it easy for people to get involved, he says.

Of course he doesn't always feel like it – 'sometimes I have to drag myself to the computer… you know what I mean, when you're a quarter of the way through the magazine…' but he's determined to keep going, and urges others not to give up easily:

'As you start out with your newsletter, you will find people in the drugs and alcohol field will promise you the earth, which ends up as lip service. I found this happened to me a number of times. I was promised funding by a member of a CDT and it came to nothing. All your emails go unanswered. You have to, hammer and chisel in hand, chip away into the system. Show you're here to stay and eventually the tide turns and people want to get hold of you.'

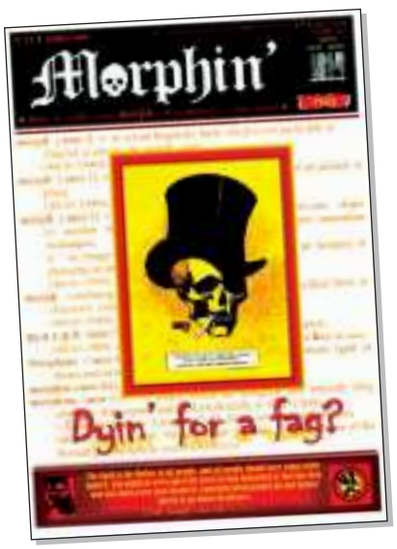
You need to persist until you find a sympathetic ear with the means to help, and David's case is proof they are out there: 'Of course there are genuine people in the drugs field who give you support and pull strings for you,' he says. 'To get anywhere in this field, you definitely need a string-puller or three.'

Southampton user group Morph started up their magazine 'Morphin', when they were searching for a way to get urgent messages out to their community.

The group initially formed 'from four of us meeting up once a week in the voluntary services building, to try and work out what to do about reducing out local waiting times,' says Simon Parry, who now works as a full-time co-ordinator for user involvement.

The outreach drug information project, in the same building, passed on information about a batch of really strong heroin that was killing people locally and nationally. 'We'd got this information and felt uncomfortable with knowing it and not passing it on,' says Simon. 'So we discussed what we could do about it and came up with the idea of an A5 single sided bulletin.' They included the warning and some information about the group – 'we've started a group, this is where we meet, these are the criteria for coming along to meetings..' – and distributed them to the day centre, mobile needle exchange, the place where people picked up their scripts, and three or four different places. 'It wasn't a particularly big thing at the start,' says Simon.

A couple of weeks later another, different, warning came along. So the idea of a monthly newsletter was born. Morphin is now over a year old and growing by around 150 subscribers an issue. Some new subscribers contact Morph because they've seen a copy of the newsletter; the rest has been trial and error, encouraging places to distribute it to service users. Some are unsure at first: 'We've had a few places say it's a bit political for us,' says Simon. 'The council housing advice service asked if they could have 50 for their waiting rooms. We were sending them out, but after a few editions they got in touch and said "sorry, the powers that be have said it's too political, could you not send it to us anymore". One of them said "could you send it to my home address..?"'



'I'll say look, if you're a drug user, the police, the prison services, the powers of state are one of your biggest problems. So to produce newsletters week after week, month after month never mentioning the old bill, is like not mentioning the elephant in the room.'

Simon is philosophical about being branded 'too political': 'I'll say look, if you're a drug user, the police, the prison services, the powers of state are one of your biggest problems. So to produce newsletters week after week, month after month never mentioning the old bill, is like not mentioning the elephant in the room.'

Simon and his partner Sue write most of the articles and aim to educate a mixed readership of service users and staff. They make the style deliberately accessible, avoiding jargon and explaining terms and acronyms. It's important not to assume knowledge if you're going to be inclusive, says Simon: 'I imagine I'm chatting to someone out on a street corner and write it in a way that your average drug user on the street would understand. I know that might sometimes seem a bit patronising, particularly when I'm putting in brackets to explain things, but I bear in mind that staff are reading it as well, and they need educating as much as service users.'

Funding for the group comes from sources like Awards for All and Community Chest and Simon has just put in a bid for £4,000 to pay for another year's worth of newsletters. It all takes effort, but the personal rewards can be high:

'We dedicated one issue to a friend of ours who'd overdosed and his missus was absolutely tickled pink that we'd dedicated the newsletter to her old man.'

Three different user mags; three different scales of operation – but all of them thriving on a growing response. So there's no right or wrong way to do it – all you need is determination, persistence and the will to communicate, even if you don't get an immediate flood of contributions. It need not be a grand enterprise; it just needs to be powered by a genuine wish to communicate. One small bit of paper can go a long way in reaching out to those who may feel phased or disillusioned by the face-to-face routes into treatment. **DDN**

I'm a project worker and want to hold an event for young people on drug safety. I'd like to do something different that doesn't involve a lecture – does anyone have any fresh ideas for engaging not preaching? And does anyone have any tips on funding?

Rob, community project worker, Lancashire

Dear Rob
This was an idea that we had for alcohol safety that might give you some ideas on engaging without preaching. We've found it to be hugely successful in capturing kids' interest and educating them before they even know that they're being taught a serious alcohol safety message.

Think B4U Drink is our educational board game about alcohol, but it's more than just Snakes and Ladders, it's a virtual drinking experience with activity, drama, tension, emotion and competition thrown in. The game is best played with 13-16 year olds, but it has something to offer for older teens and adults too.

We have trained about 200 staff from high schools, community learning and voluntary organisations in Grampian to be Think B4U Drink Gamesmasters. The game is now two years old, and has recently been improved after evaluation. What teens say about Think B4U Drink is how much fun you have playing, how real it is, and how much it gets you thinking.

It is fascinating when people get into character and get into the reality of drinking in the play park, by the river, at a hotel function, or at their mate's house. Teens often play as themselves, are very knowledgeable, and challenge each other mercilessly. They are more than happy to furnish you with tales of 'the time I went to throw up and the bog lid was down', but they can also get really competitive about getting the facts right, and they remember them.

When you're playing Think B4U Drink with young people, they don't want to hang around. They plan their night quickly, then they can't wait to pick up drink, get on with virtual drinking and get to the consequences! Designing the game we felt that it was important to have some planning involved. After all, if they were planning their night out for real, they'd be thinking about what money they had, where they could pick up alcohol *etc*. (Never mind the three hours in the bathroom). So we spend five minutes or so planning this in teams and sharing it with the group.

Out on the streets on their way out, the atmosphere is sometimes controlled, and sometimes loaded. We suggest people take a reasonable amount of money, but they can be really creative with it. There is more risk here, with 'Chance' cards, that crucial element of risk – there is no guarantee that in reality you will be able to pick up alcohol from somewhere if you're 13, so in the game it's all in the way you 'spin the bottle' (like throwing a dice). You could land up with more money, or a free take away, finding drugs, or doing a dance and singing in front of your mates.

Once the drinks are in (or not), the teams hurtle (like in a trolley dash in Boozebusters), to their location for the night where they can start their virtual drinking, answering drinking questions on the way. This part is where the skill of the Gamesmaster comes into its own, encouraging, pressurising, bribing or bullying teams (depending on your style) into getting their luvvie hats on and doing a 'Gielgud gets drunk and climbs a tree', or 'Olivier and his mates have a few too many and try to make chips'. The messages are serious though – what would you do if your mate had an accident and you were really drunk, as compared to tipsy? How would you feel if your drunken mates smashed up the playpark where your little brother played? How would you react if someone spilled your drink or knocked you when you were pissed? Where would your reaction get you?

On the way home again, there are more hazards, pitfalls and diversions to nudge players into thinking about what might happen, depending on how much they've had to drink. Losing keys, snogging someone else and your boy or girlfriend sees, getting stopped by the police, going to the chippy *etc*. To finish we all chip in (pun intended!), look at how the night went, and talk about what we might do differently next time.

We have had loads of calls from other areas about Think B4U Drink. We now have 1500 games available to sell sitting in storage in Aberdeen, and we will be able to support new areas with Gamesmaster training sessions. The Scottish Executive are very positive about Think B4U Drink (the Substance Misuse Division have played it - I'd have loved to run that session!), but they can't commit any funding yet. If any kindly benefactors are reading we are looking for sponsorship so we can get the game marketed properly and have a full time contact person for training and development. We are offering an attractive package with co-branding on the game, packaging, website, advertising and PR. What's next? Lots more fun developing the Big Think B4U Drink Game, the street and online games and the UK version!

Sarah Dalgarno,
Grampian Think B4U Drink Committee
(For interest in the game, contact sarah.dalgarno@nhs.net)

Dear Rob
I would recommend a Theatre in Education piece, a small play written specifically to engage your Young people which includes a workshop afterwards that asks them to interview the characters and ask why they did what they did.

Also try a mock court case, which gradually reveals a more complex case that gradually changes the young people's minds on who's guilty of what – *ie*, initially it seems its a cut and dried case of GUILTY. (You can incorporate motivated by bullying or whatever.)

This way they get some awareness of the issue and education on how courts go on. You may like to ask a friendly local magistrate to help you do this.

Also you could try telephoning or writing to your local Drug and Alcohol Action Team and Crime and Disorder Reduction Partnership to ask about bidding into their various pots of money.

Good luck!

Nina Dauban, Manager of Hettys & WAM

Dear Rob
I work as a volunteer for CRI at the St. Thomas Fund Residents Care Home in Brighton.

If you want to engage the young people of your community without preaching or lecturing, I recommend having a party. You could hire out a school hall for instance. Set out a dancefloor, and around the sides set up a long bar where you might serve fresh fruit mixes, ice crushes, pick your own fruits and blend *etc*.

As your bartenders, you could have 6-7 knowledgeable people each representing a different drug, indicated by a poster or banner behind them. The youngsters could then go along the bar, getting drinks and eats, while asking questions and chatting about the different drugs and their dangers in a very informal way. Having learned chunks of info from talking to the bartenders they could then discuss, gossip, and swap info amongst themselves.

There is another benefit to this: I remember a weekend when the residents at St. Thomas Fund went to a party at an NA meeting. They all had a great time and it was like a revelation to them that they could actually have a such fun dancing and partying without Drugs or Alcohol! It was such a boost.

If your young people can learn that you don't need Drugs or Alchohol in order to boogy-on-down and have a cracking party, that might be as valuable as the knowledge they might gain in the process.

As to funding, this option might be cheap, and any school, college, or Uni you ask should have the sense to go for it.

With respect,

Mike Richardson, CRI, Brighton

Reader's question

I've completed rehab and I'm desperate to work in the field as I feel I can give a lot back. I am optimistic about my future, but I'm worried about how my history of drug dependency will look on paper to any prospective employer. Can anyone give me guidance on presenting myself honestly without destroying my chances of a full-time job?

Simon, Brighton

Email your suggested answers to the editor by Monday 18 July, for inclusion in the 25 July issue of DDN. New questions are welcome from readers.

Should recreational drug use be criminalised?

Professor David Clark continues his look at the regulation and control of drugs by presenting the views of the philosopher Douglas Husak about the justice of drug laws in the United States.

Douglas Husak combines hard fact and rigorous moral reasoning in his cogent analysis of the drug law debate in his recent book *Legalize This! The case for decriminalising drugs*. We summarise his arguments – and do not offer our own view - to help the reader decide how they feel about the central question of the justice of drug laws. Whilst Husak argues about the situation in the US, much of what is said is relevant to the UK.

Husak points out that we need to ask the right question when looking at drug policy. He emphasises that the onus has always been on those who want to change drug laws to justify why there should be changes. In fact, the onus should be on those who support current policy to justify their position. This rarely happens.

The critical question to be answered is: should recreational drug use be criminalised? Husak analyses the reasons put forward by prohibitionists to justify why people should be punished for recreational drug use.

The most pervasive argument is that drug users should be punished to protect children. Husak argues that the state is not committed to child welfare generally, since millions live in poverty and lack health insurance, and schools are under-funded, *etc*. Moreover, concern for the welfare of children vanishes when a child begins to use drugs – there is a growing trend in the US to prosecute and sentence children as if they were adults. The concern that children remain drug free disappears when doctors purport to detect a syndrome that requires the use of drugs, *eg* about five million children in the US take ritalin, an amphetamine-like stimulant.

Husak asks how punishing adults protects children. Are not adults instigating the behaviour we are trying to prevent? The myth of the pusher at the school gates has been wholly discredited – peers introduce children to drugs.

The Office of National Drug Control Policy (ONDCP) argues that the second most important objective of US drug policy is 'to increase the safety of America's citizens by substantially reducing drug-related crime and violence'.

Prohibitionists often point out that a high percentage of criminals test positive for illicit drugs. More meaningful, is the fact that an extraordinarily low percentage of drug users commit non-drug crimes. If drug use causes crime, why do the vast majority of drug users not engage in crime?

'I think the sheer scale of incarceration of drug users makes prohibition the worst injustice perpetrated by our system of criminal law in the 20th century. Only the institution of slavery and the despicable treatment of the Native Americans are greater injustices in the United States.'

Douglas Husak

Three types of crime are linked to drug use. Systemic crimes occur because drug use is illegal and illicit drugs are bought and sold in black markets. A major study conducted in New York in 1988 revealed that 85 per cent of all crack-related crimes were systemic crimes: they were caused by the market culture associated with crack sales, primarily territorial disputes between rival dealers.

Economic crime arises because some addicts need money to pay for their drug use. Husak points out that only 25 per cent of adult prison inmates in the US who use illegal drugs and commit economic crimes cite their drug use as a primary motivation for becoming involved in criminal activity. Many such people are committing economic crimes before they started taking drugs.

Psychopharmacological crime arises from the effects of the drugs themselves. The drug that most likely causes psychopharmacological crime is alcohol. In 1998, it was reported that 21 per cent of persons in US state jails or prison for violent crime were under the influence of alcohol and no other drug at the time they committed the crime. Only 3 per cent were under the influence of cocaine or crack alone, and 1 per cent were under the influence of heroin alone.

It is argued that drugs are bad for our minds and bodies. Whilst few prohibitionists state explicitly: 'The state is justified in punishing drug users because illicit drugs are bad for our health', this rationale is endorsed implicitly.

Illicit drugs do pose risks to physical and psychological wellbeing. However, whilst the state has a central role in protecting the health of its citizens, it does not ordinarily perform this function by punishing the very people whose health it endeavours to protect. If you eat spoiled meat, do you get sent to prison?

Prohibitionists also emphasise the public expense incurred when people make unhealthy choices. So does this mean we should send people who use drugs recreationally to prison in order to reduce insurance premiums and conserve public resources?

Husak also asks how criminalisation improves health? He questions whether the health of drug users improves in prison.

According to the ONDCP, about 25,000 Americans die each year from using illicit drugs – the majority are caused by drug prohibition, not by the drugs themselves. Approximately 100,000 people die each year from adverse reactions to prescription medications, whilst over 100,000 people die each year because of alcohol. At least 430,000 die each year because of tobacco.

Many activities that do not involve use of a drug are far more risky to health, even though no-one would dream of using the criminal law to prohibit them. More than half of all Americans are now overweight. According to the Centre for Disease Control and Prevention, obesity accounts for about 300,000 deaths a year.

Husak finally refers to the moral view of prohibitionists. The former drug czar William Bennett said, 'I find no merit in the legalisers' case. The simple fact is that drug use is wrong. And the moral argument, in the end, is the most compelling argument'.

A more detailed description of Husak's arguments can be found in his book – an excellent read – or in the About Drugs section of www.substancemisuse.net.

drugtrain

Working collaboratively to promote excellence in drug & alcohol work through training

Sheffield Hallam University

Certificate in Drug and Alcohol Counselling – recruiting now for October 2005 start, deadline for applications 27th July 2005

This 2 year part-time course offered in partnership with Sheffield Hallam University provides comprehensive therapeutic training in the Cognitive-Behavioural model of substance use for current drug / alcohol workers and those new to the field who wish to pursue a career in Drug and Alcohol Counselling. The course includes supervised work experience in Year 1 and supervised counselling practice with drug / alcohol clients in Year 2. Attendance is 1 day per week (Thursdays) for Year 1, plus a residential weekend, reducing to 1 day per fortnight in Year 2.

Modules:

- Studying Substance Use
- Personal Awareness
- Introduction to Cognitive Behavioural Counselling Skills
- Drugs Worker Skills
- Specialist Counselling for Substance Misuse
- Supervised Counselling Practice
- Developing as a Counsellor
- CBT for Common Problems

Qualification:
Certificate in Higher Education consisting of 120 credits at Level 4. Successful completion of the course will provide participants with the main skills and knowledge required by the Drug and Alcohol National Occupational Standards (DANOS).

Short courses
(OCN accredited and non-accredited)

- Drug/Alcohol Awareness e.g. *Alcohol Facts*; *Drugs Awareness Levels 1,2,3*
- Skills Development e.g. *Motivational Interviewing*; *Relapse Prevention*
- Professional Development e.g. *Introduction to Cognitive Behavioural Therapy for Drug Workers; Mental Health and Substance Use; Parental Substance Use and Child Protection*

NOCN

Coming soon – new NOCN suite of Level 3 qualifications in *Tackling Substance Misuse* with 5 endorsed routes:

- Commissioning and Planning Services (aimed at service commissioners and others involved in managing local strategies)
- Practitioners (aimed at Drug Workers)
- Drugs Education
- Managers (aimed at senior practitioners and team leaders in drug treatment services)
- Generalist Worker (aimed at those with another specialism but taking a special interest in working with drug users).

In order to achieve this DANOS mapped qualification, a learner must complete a total of 15 unit credits at Level 3 made up of:

- One mandatory unit at 6 unit credits
- A choice of optional units at 9 unit credits

In-house bespoke training

We are also keen to bring our training to you. All courses can be run within your organisation and the drugtrain team can offer bespoke training to meet your exact needs. We are experienced in designing and facilitating effective team building and planning events.

For a prospectus, application pack and further information contact:
Steph Windle,
Training Administrator,
drugtrain,
Sheffield Alcohol Advisory Service,
646 Abbeydale Road,
Sheffield S7 2BB
0114 258 7553 ext212
steph.windle@sheffieldaas.org.uk

drugtrain is a collaboration of community based drug and alcohol treatment agencies which have a proven track record for high quality vocational training, comprising:

- *Sheffield Alcohol Advisory Service (SAAS)*
- *Barnsley Alcohol & Drug Advisory Service (BADAS)*
- *Rotherham Community Alcohol Service (RCAS)*

Our aim is to promote excellence in drug and alcohol work through innovative training which cultivates the development of a committed, high-quality workforce

rcas badas SAAS

the WAREHOUSE DUDLEY DRUG PROJECT

The Warehouse (Dudley Drug Project) is an independent community based drug project (Charity no. 1020293) based on three sites incorporating both adult drug services and young people's substance misuse services, with a growing portfolio of partnerships (Community Safety, Police, Health, Probation, YOS), providing a range of counselling, information and treatment services for Dudley (West Midlands).

We are currently looking to recruit qualified workers (e.g. DipSW/Y&C, RMN/RGN, Dip Couns) to join our dedicated teams of paid and volunteer staff. With experience in the substance misuse field, you will support, deliver and develop referral and treatment services.

The Warehouse Adult Treatment Services

Drug Worker, Drug Misusing Parents (W1)

Salary scale A&C 6, £21,549-£25,212

You will provide treatment and support for drug using parents and pregnant women.

The Cage Criminal Justice Services

Family Support Worker (C1)

Salary scale A&C 6, £21,549-£25,212

You will provide support for parent/carers of adult drug users in the Drugs Intervention Programme.

Drug Worker (0.4 FTE) (C2)

Salary scale A&C 6, £21,549-£25,212 pro rata

To provide treatment and support for drug users in the criminal justice system.

The Zone Young Peoples Substance Misuse Services

Young People's Drug Worker (Z1)

Salary scale A&C 6, £21,549-£25,212

To provide treatment and support for drug users under the age of 18.

All posts full time except where specified.

Closing date for receipt of applications: July 22nd 2005.

For informal enquiries and job packs, please call 01384 480058, Fax 01384 481868.

Please state reference number for relevant post.

Charity no. 1020293

SOUTHAMPTON CITY COUNCIL

Safe City Partnership making Southampton safer

SOUTHAMPTON CITY COUNCIL

TENDER FOR PROVISION OF OPEN ACCESS DRUG SERVICE

SOUTHAMPTON CITY COUNCIL invites applications from suitably experienced organisations who wish to be considered for selection to tender for the provision of Open Access Drug Services within Southampton.

The service to be commissioned by the Southampton Safe City Partnership will be for open access provision to a range of community based services for people with problems relating to primary drug use. The core function of this service is to target drug users from Tier 2 severity level. The contract period will be for 3 years.

The Open Access Drug Service will work in partnership with other drug treatment and support service providers who cover the City, within a tier-based structure of care delivery for treatment of substance misuse.

Organisations interested in being considered for invitation to tender should apply in writing to Miss S O'Neill, Corporate Procurement, 1st Floor, Southbrook Rise, Millbrook Road East, Southampton S015 1YG (email sharon.o'neill@southampton.gov.uk) by no later than 12 noon on 27th July 2005. Applicants will be required to complete a pre-qualification questionnaire which must be returned by no later than 4pm on 5th August 2005.

Further information on the service requirements can be obtained by contacting Joan Ward on Southampton 023 8083 4257 or email: joan.ward@southampton.gov.uk

The contracting authority undertake to use reasonable endeavours to hold confidential any information provided in the proposal submitted, subject to the contracting authority's obligations under law, including the Freedom of Information Act 2000. If the applicant considers that any of the information submitted in the proposal should not be disclosed because of its sensitivity then this should be stated with the reason for considering it sensitive. The contracting authority will then consider the sensitivity statement before replying to any request received under the Freedom of Information Act 2000.

Tender documents or notice of non-acceptance, as appropriate, will be sent to all applicants.

The Training Exchange

The Training Exchange Drug & Alcohol Training Programme Autumn/Winter 2005/6

the TRAINING exchange

One day courses (£95 + VAT)

Introduction to Drugs Work	13th October
Alcohol & Poly Drug Use	3rd November
Difficult & Aggressive Behaviour	21st November
Working with Diversity	30th November
Drugs & Housing	1st December
Personality Disorders	13th December
Crack Awareness & Users' Needs	14th December
Service User Involvement	17th January 2006
Women & Drugs	25th January 2006
Steroids & Steroid Users	31st January 2006

Two day courses (£180 + VAT)

Motivational Interviewing	19th & 20th October
Brief Solution Focussed Therapy	10th & 11th November
Relapse Prevention	6th & 7th December
Dual Diagnosis	19th & 20th January 2006
Young People - Mental Health& Emotional Support Needs	1 & 2 February 2006

All the courses in this programme are mapped to DANOS.

All courses take place in Bristol.

For further details and full course outlines contact
The Training Exchange,
Easton Business Centre,
Bristol BS5 0HE
Tel/Fax: 0117 941 5859
email: admin@trainingexchange.org.uk
www. trainingexchange.org.uk

The Training Exchange is an independent training and consultancy service. We focus on issues that affect health, young people and communities.

KCA (UK) is an expanding and vibrant organisation providing a wide range of high quality and innovative specialist services. Founded in 1975 and currently employing over 200 paid and unpaid staff, it has an annual income of £5 million and is becoming established as one of the leading service providers in the South East Region. Our aim is to deliver individually tailored care packages which are effective in reducing drug and alcohol related harm and are based on cost-efficient structures, processes and delivery mechanisms.

K·C·A
Services in the Community

Ref 289 – Community Drugs Workers

Salary £19,656 - £25,437 (SCP 25-33) – 37 hours per week
Essential Car User Allowance

Working closely with medical staff, you will provide assessment and keyworker support to service users accessing the substitute prescribing service. The aim of the role is to assist chaotic injecting drug users to stabilise their drug use and lifestyle.

Significant experience of working with people with drug related problems, a genuine commitment to this client group and a background and qualification in nursing or other relevant profession are essential.

There is scope to be involved in developing associated specialisms within the team.

For application forms contact:
KCA (UK), Dan House, 44 East Street, Faversham, Kent ME13 8AT.
Telephone 01795 590635, Fax 01795 539351,
Email marina@kca.org.uk, www.kca.org.uk

Closing date: 15th July 2005
Interview date: 27th July 2005 in Ashford

KCA (UK) is committed to the principles of equality of opportunity for all and welcomes applications from people with experience of substance use or who have had previous problems with substance misuse.
Charity No: 292824

GDAS (Gloucestershire Drug and Alcohol Service) is the countywide non-statutory substance misuse agency providing a range of services for people experiencing problems with their own or someone else's drug or alcohol misuse.

SUST Service Co-ordinator

£18,137 +3% non contributory pension

A new post has arisen for the position of SUST (Service Users Support Team) Service Co-ordinator. The aim of the role will be to manage and develop SUST through co-ordinating, developing and supporting drug and alcohol Service User involvement throughout Gloucestershire. You will need to have direct experience of being a service user of drug and/or alcohol services.

Shared Care Project Worker

£20,771 + 3% non contributory pension

A Shared Care Project Worker is required to work within the West Glos PCT in the GP's Clinics for part of the week and within the PCT Alcohol Project in the Forest of Dean for the rest of the week, so independent transport is an essential for this role. You will have a minimum of 2 years experience of working in the drug and alcohol field along with a range of skills including working with individuals to bring about change, groupwork skills, excellent interpersonal and communication skills.

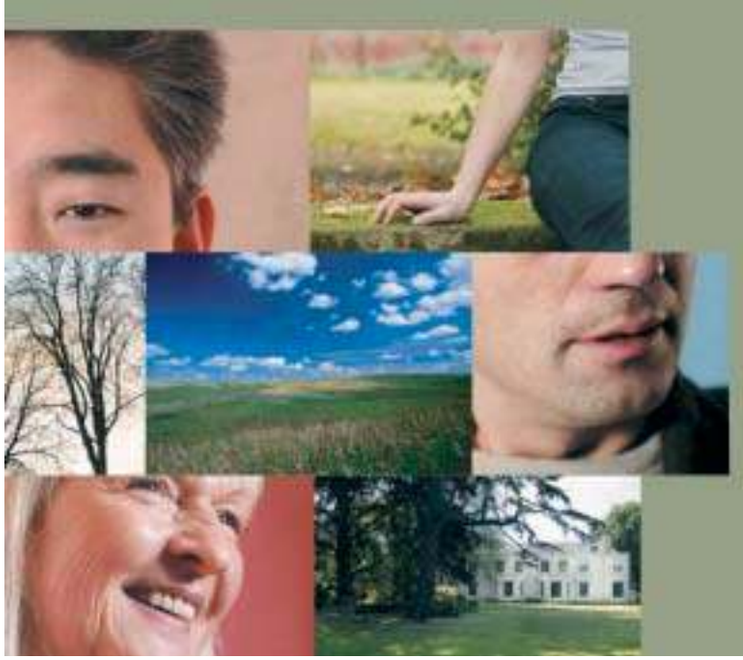
Flexibility, a commitment to harm reduction and a willingness to work as part of a team are essentials for both posts.

For an application pack for either of the posts please contact: Louise Owen on 01452 553314

For an informal discussion on Shared Care please contact Cynthia Kerr 01452 553342

Closing date Friday 22nd July 2005

LIFE WORKS
TRANSFORMING LIVES



Clinical Manager, Counsellors & Support Staff

Life Works is a progressive and dynamic residential treatment centre in Surrey, providing high quality, individual-specific treatment for addictions, compulsive behaviours and related mental health issues. We are now expanding our service to include a new Day Centre on Duke Street, London, W1.

A chance to be part of something exceptional...

Due to unprecedented growth and demand for our services, we are currently recruiting passionate and high quality individuals in London and Surrey for the following positions:

- Clinical Manager (London)
- Primary Counsellors
- Clinical Psychologist
- Bank & Part-Time Counsellors, Trainee Counsellors, Student Placements & Care Workers

A recovering background is a plus but the passion and commitment to make a real difference and be part of an innovative organisation is a must. To apply for any of the above positions, please send your CV with salary history to dserratt@lifeworkscommunity.com

For further information please visit

www.lifeworkscommunity.com

CLOUDS

ADDICTIONS COUNSELLORS

Salary range £19,510 to £21,215 plus benefits

Since 1983, the charity Clouds has directly and indirectly helped thousands of people from all walks of life to recover from the effects of alcohol and drug addiction. Clouds has always worked tightly to the vision of offering help, hope and freedom from alcohol and drug dependency by providing interrelated services of the highest quality and effectiveness, all of which have a clear and ethical basis and which meet the REAL needs of our clients.

To continue the good work, we are seeking to recruit qualified Addictions Counsellors who will be able to provide a full range of Counselling Services to our beneficiaries.

Clouds House is situated within beautiful countryside providing you with a setting to complement your skills and experience. Our benefits include a non-contributory personal pension scheme, minimum of 25 days holiday and Death-in-Service benefit.

For more information and to receive the application pack, please contact Mardeen Willows, Human Resources Assistant, on 01747 830733. Alternatively, please email your interest (providing a postal address) tomardeen.willows@clouds.org.uk

Closing date: 22 July 2005

Clouds, Clouds House, East Knoyle, Salisbury, Wiltshire SP3 6BE

www.clouds.org.uk

Project Worker

required by Guildford Action
Full-time (37.5 hrs p/w),
based at our Centre in Guildford.

Non-judgemental approach needed for a varied client group.

Salary £15,268.00 per annum

Please contact Sara on 01483 533943 for an application pack.

Guildford Action is a registered charity no. 1078721, registered company no. 3767533

Your Life, Your Community
Your Opportunity



Stonham is England's largest specialist provider of housing and/or support for socially excluded adults and young people.
Stonham runs 590 services, working in partnership with local authorities, health care providers, probation services and others delivering services to 14,102 people each year.

Deputy Approved Premises Manager

PROSPECTS PRESTON
Reducing drug-related crime in our community

Prospects - Preston, £27,771 - £30,693 pa, 35 hpw Ref: N3DAPM60

Prospects House is a partnership between Stonham, Preston Prison and the National Probation Directorate. It is a 3-year pilot project due to come into operation in December 2005. Prospects will offer supported accommodation to 12 ex-offenders with drug related offending backgrounds released directly from HMP Preston, and will operate as a Home Office Approved Premise in Preston. The regime will include an intensive 12-week programme of life skills and drug interventions. Prospects will link in with the local Prison CARAT's team and provide a 12-week supportive residential programme for prisoners on release. After this time they will be assisted into permanent accommodation in the community.

We are looking for an enthusiastic, energetic manager with at least two years' experience of managing staff teams to help develop and manage this innovative service. You will possess a 'can do' attitude, exceptional people skills, determination to make the service the best and the ability to train and lead Project Workers in sound practice within a structured framework.

A qualification in one of the following, or similar, is essential - social work, mental health nursing, addictions counselling and/or BSc Housing or Professional Housing Qualification. Post under evaluation.

We offer:

- flexible working practices
- excellent training and career development
- enhanced benefits
- opportunities for promotion
- A supportive environment and a partnership in truly worthwhile work.

Applicants will be subject to Criminal Records Bureau checks as part of the recruitment process.

You can find more information and apply online at www.sector1.net

Alternatively, for a recruitment pack please telephone 0845 408 9750 or email: stonham.housing@pearsons.co.uk quoting the relevant reference number.

Closing date: 29th July 2005.

Stonham is a division of Home Group Ltd. (Charitable I & P Society No. 22981R).

business for neighbourhoods

www.stonham.org.uk or www.sector1.net for more vacancies within this organisation

We welcome applications from all sections of the community

Stonham

Are You Looking For Staff?

We have a comprehensive database ofspecialist substance misuse personnel

DAT Co-ordinators ● RoB Co-ordinators ● Project Workers ● DIP Workers Counsellors
Commissioning Managers ● PPO workers ● TCAC workers ● Case Managers

Consultancy, Permanent, Temporary

"We have found Solutions Action Management to be a focussed professional and responsive provider of both Consultancy and interim management support as well as helping with our permanent DAT coordinator/ recruitment. They have been able to target our own specific needs and have provided high calibre candidates for us."
Chief Executive – Slough PCT

www.SamRecruitment.org.uk

Contact the Director to discuss your recruitment needs: Samantha Morris Tel/Fax 020 8995 0919

Challenging Addiction

At Phoenix House we're in the business of helping substance misusers rebuild their lives. Our innovative range of services include prison projects, community based initiatives and holistic rehabilitation programmes across the country – and we are continually developing and extending our expertise to meet the changing needs of our clients.

In a recent procurement exercise with Her Majesty's Prison Service, Phoenix House won a number of contracts to deliver drug treatment services. In partnership with the London Area Office we are looking for a number of Drug Workers for our rehabilitation units at HMP Brixton and HMP Pentonville. HMP Brixton is a Category B Prison housing around 750 men. HMP Pentonville is also a category B Prison housing around 1,200 men. Have you got what it takes to join us at these key projects?

FULL & PART TIME PRISON DRUG WORKERS – REHAB

£22,427 - £25,370 pro rata • Pentonville and Brixton

Working as part of the drug rehabilitation Prisons Addressing Substance Related Offending (PASRO) team, you will carry a challenging personal caseload working directly with offenders, both individually and in groups. You will deliver the programme in accordance with HMPS directives whilst drawing on your own skills, knowledge and experience to get the best out of the client group.

Previous experience of working within rehabilitation, treatment and re-offending prevention services would be beneficial. PASRO training will be given. The part time position is approximately 18 hours per week and is based at Pentonville. The starting salary for this post is £22,427 or £23,015 pro rata depending on experience. The higher salary in the range can be achieved through annual performance appraisal. There are also opportunities to progress to Treatment Managers positions after 6 months. **Ref: PDW/PB/B2 (full time), or PDW/PB/1 (part time).**

Along with an attractive salary, you will receive a first class range of benefits including a final salary pension scheme, generous holidays and ongoing training designed to support your personal and professional development.

For further information or to download an application pack please visit www.phoenixhouse.org.uk or email recruit@phoenixhouse.org.uk quoting the appropriate reference number. Alternatively please call our recruitment line on 020 7234 9772. Closing date: Monday 25th July 2005.

phoenixhouse
www.phoenixhouse.org.uk Rebuilding Lives

35 years of rebuilding lives

Committed to a policy that promotes equality and diversity
Charity registration number: **284880**

brighton housing trust

BHT Addiction Services

BHT's Addiction Services provide a comprehensive programme of support to men and women, many of whom are former rough sleepers in the City, who are committed to abstinence and recovery from their addiction to drugs and alcohol.

Project Worker (The Recovery Project)

Salary £19,656 – £21,654 pa, plus 3% (reviewed annually) pension contribution
NJC scale point 25, rising by annual increments to NJC scale point 28
Working 35 hours per week

Annual leave entitlement starts at 25 working days pro rata

The Project Worker is required to assist in the day-to-day running of the Recovery Project, which includes individual keyworking, group work and other therapeutic interventions, as well as developing a range of activities aimed at supporting clients to re-establish themselves in the community.

With experience of supporting people in the early stages of recovery from addiction and a creative and imaginative approach to problem solving, the post holder will be joining at an exciting time, with the project now at the centre of a thriving community of recovering men and women in the City.

Closing date: 12 noon Monday 25th July 2005.
Interview date: Tuesday 2nd August 2005.

This post is exempt from the provisions of the Rehabilitation of Offenders Act of 1974.

For further details and an application form, please write to the HR Administrator, Brighton Housing Trust, 144 London Road, Brighton BN1 4PW, specifying the post you are interested in and enclosing an A4 self-addressed stamped envelope (44p). Alternatively, if you would like these documents emailed to you, please email jobs@bht.org.uk

Please note CV's will not be accepted.

BHT operates an Equal Opportunities Policy.

DAF

Drug and Alcohol Foundation

COMPLEX NEEDS WORKER (Female)

Full time (37.5 hours) 8 month contract

Salary £21,000 - £24,000, plus pension

We are looking for an enthusiastic, female worker to join our small team, providing structured day services to clients with co-existing substance misuse and mental health problems.

The service works with clients who are abstinent and those who are currently using drugs or alcohol.

This position would suit a drugs worker with some experience of providing harm minimisation interventions to clients in a community setting. Experience of working with complex needs including mental health problems and offending behaviour, would be an advantage.

The post holder will be expected to conduct client assessments, provide key working, low threshold group work, and with the support of colleagues, to provide diversionary activities including art, computer literacy and relaxation.

Training in mental health issues and the treatment of Dual Diagnosis, will be available to the successful candidate.

Closing date for applications is 5 August 2005

For an application pack please contact:
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